

Date Rec'd _____
 Date Replied _____

**REQUEST FOR INFORMATION
 REGARDING NOTICES OF TERMINATION
 FROM PROSPECTIVE EMPLOYERS**

Name of Licensee		
Address		
City/State/Zip		
SS# or DOB		
Type of License		Idaho License No:
Employer		
Address		
City/State/Zip		
Phone/Fax Numbers		
Name of Person Requesting Report		

I hereby swear that this request is being made for the bona fide purpose of hiring and is made pursuant to the provision of Section 37-117A Idaho Code. I agree not to disclose this information to any other person or entity without the prior written approval of the health care provider or as required by law, court order or rules of civil procedure.

Signature	Date
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AFFIDAVIT

State of Idaho)
) ss
 County of _____)

On this _____ day of _____, in the year of _____, before me _____, a notary public, personally appeared _____, personally known to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

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 Notary Public
 My Commission Expires on _____

Complete the above information and return to:
 Idaho Board of Medicine
 PO Box 83720
 Boise, ID 83720-0058
 Fax: 208-327-7005
info@bom.idaho.gov

Reply

- No Notice of Termination on File for the above requested licensee
- Notice of Termination on File – see attached.



Information provided in the Notice of Termination has not been verified by the Board